Department of Health Care Policy and Financing

Introduction

The Department of Health Care Policy and Financing (DHCPF) was created as part of the restructuring of state departments under HB93-1317 effective on July 1, 1994, or the beginning of Fiscal Year 1995. The Department is the state agency responsible for administering the federal Medicaid program, the federal program designed to provide health services to eligible needy persons. DHCPF contracts with the Department of Human Services for some services, such as determining individuals' eligibility for Medicaid services. The Medicaid grant is the largest federal program administered by the State and is funded approximately equally by federal and state general funds. In Fiscal Year 1998 the Medicaid caseload was approximately 258,800, representing a decline from the previous year of about 3.8 percent. During Fiscal Year 1998 the Department expended almost $1.67 billion and had 146 full-time-equivalent staff (FTE), compared with $1.59 billion in expenditures and 133 FTE in Fiscal Year 1997.

During Fiscal Year 1998 the Department also worked on developing an expanded children's health insurance program for children through 18 years of age as authorized by HB97-1304, referred to as the Children's Basic Health Plan. In October 1997 the Department submitted the State's plan for children's health insurance to the federal government in order to obtain federal funds for these types of programs under the new federal Title XXI, the Children’s Health Insurance Program.

The public accounting firm of Ernst & Young, LLP, performed the audit work at DHCPF as of and for the fiscal year ended June 30, 1998. During its audit Ernst & Young reviewed and tested DHCPF's internal controls over accounting and administrative functions and federal programs, including compliance with state and federal laws and regulations.

Obtain Approval for Cost Allocation Plan

Under federal regulations, entities that receive federal awards, referred to as grantees, may be reimbursed for a portion of indirect costs related to operating a federal program. Indirect costs are similar to overhead costs (e.g., the purchasing or human

resources function), or costs incurred by an entity that cannot be directly attributed to a single program or activity but provide some type of benefit to the program.

Federal regulations require that in order to receive reimbursement for a portion of these indirect costs, the grantee must develop a cost allocation plan and submit it to the appropriate federal oversight agency. The cost allocation plan describes the agency's proposed method for distributing indirect costs across its programs and thereby receiving reimbursement for some share of indirect costs. The federal agency is responsible for reviewing the plan, negotiating any required changes with the grantee, and, when acceptable, approving the plan. Similar to other state agencies, the Department of Health Care Policy and Financing uses state general funds to pay indirect costs and then receives reimbursement from the federal government for the federal share.

Technically, an agency is required to have an approved cost allocation plan in place before the start of its fiscal year. However, delays may occur if significant changes have taken place in the agency's structure or in its methodology of allocating indirect costs. If an agency does not have an approved plan for the period, it attempts to reach a temporary agreement with the federal oversight entity concerning how indirect costs will be reimbursed until negotiations are completed.

After the federal entity approves the agency’s cost allocation plan, the amount of indirect costs reimbursed to the grantee based on the temporary agreement must be reviewed to ensure the amount received was appropriate based on the negotiated methodology. As a result of this review, the grantee may need to repay monies to the federal government, or the grantee could be reimbursed additional amounts, depending on whether the grantee has over- or underrecovered indirect costs during the negotiating period. If the federal government believes that negotiations are not proceeding appropriately, it can either disallow costs previously reimbursed, defer reimbursement for any indirect costs until an approved plan is in place, or both.

The Department Has Not Had an Approved Plan Since Its Inception in Fiscal Year 1995

Although the Department has taken steps to complete a cost allocation plan, it has not had an approved plan in place since the agency's inception on July 1, 1994. For Fiscal Year 1995 the U.S. Department of Health and Human Services approved a temporary rate of 10.71 percent of the pool of direct program costs, which was defined as direct program salaries and benefits. This was the same rate that was used for Medicaid under the former Department of Social Services, which was responsible for the state Medicaid program through Fiscal Year 1994.

In Fiscal Year 1996, responsibility for the approval of the Department's plan was transferred to the Health Care Finance Administration (HCFA), the federal Medicaid agency. HCFA required that the Department directly charge all indirect costs to programs based on some reasonable allocation of these costs, rather than using an indirect cost rate. Therefore, since the beginning of Fiscal Year 1996 the Department has received reimbursement for indirect costs based on allocating these costs directly to its programs.

Staff report that very little of the Department's expenditures are for non-Medicaid programs; they estimate that roughly less than 1 percent of the Department's expenditures were for non-Medicaid programs during Fiscal Years 1996 and 1997. Therefore, although the Department did not have an approved cost allocation plan, staff believe that the amount of indirect cost recoveries received from the federal government is reasonable. Beginning with Fiscal Year 1998, however, staff indicate that the allocation process became more complex because the Department became responsible for the federal Children's Health Insurance Program and several other smaller federal programs and private grants.

The Department reports that it has collected an average of $1.5 million to $1.75 million in indirect cost recoveries annually from federal programs, or about $6 million to $7 million from Fiscal Year 1995 through Fiscal Year 1998. The federal Health Care Finance Administration has indicated that if the Department does not complete the submission of its cost allocation plan in the next several months and if an agreement is not reached, HCFA will consider deferring future requests for reimbursement of indirect costs. If this occurs, until a plan is approved the Department would no longer be reimbursed for the state general funds used to pay the indirect costs related to federal programs.

Department Has Taken Steps to Obtain an Approved Plan

There are two primary components that DHCPF must submit to the federal government in order for negotiations to be completed and for a plan to be approved.

- The Department must submit a narrative describing the model that will be used to allocate indirect costs to federal programs and obtain reimbursement for a share of these costs.

- The Department must complete a reconciliation showing that the amount of indirect costs that would have been collected by DHCPF under the *proposed model* is reasonably similar to the *actual* share of indirect costs incurred for

federal programs during a specific period. Normally, these reconciliations are done for each fiscal year.

In May 1998 the Department met the first requirement and submitted the narrative to the federal government. At that time it also furnished a reconciliation of proposed and actual indirect cost reimbursements through 11 months of Fiscal Year 1997. However, it has not been able to complete the reconciliation for the entire year. Although HCFA has been receptive to the narrative furnished by the Department, it will not negotiate and approve a plan until a completed reconciliation for Fiscal Year 1997 is submitted, and it has assessed the reconciliation.

Various Factors Have Delayed Completion of the Cost Allocation Plan

The Department reports that there are several reasons for the delay in submitting the necessary materials to the federal government. These include delays encountered because the Department brought in a contractor to develop software for the plan; the change in federal oversight agencies from the U.S. Department of Health and Human Services to HCFA; and problems with earlier efforts to perform reconciliations between the proposed model and actual costs for Fiscal Years 1995 and 1996. DHCPF staff indicate that they were unable to do the Fiscal Year 1995 reconciliation because some microfiche had been misplaced and not all necessary data were available. Staff reported the Fiscal Year 1996 reconciliation was not completed because the Department reorganized during the year, and the resulting lack of consistency in recording costs throughout the year made it very difficult and time-consuming to track costs needed for the reconciliation. As a result of these problems, during Fiscal Year 1998 HCFA agreed to allow the Department to perform the required reconciliation for Fiscal Year 1997. If the Department can complete the Fiscal Year 1997 reconciliation to HCFA's satisfaction, that year will be used to make gross adjustments for Fiscal Years 1995, 1996, and 1997. Negotiations regarding the Fiscal Year 1998 plan must then be completed. Since Fiscal Year 1998 is the first year that the Department has administered the federal Title XXI grant, the Department believes the agreement reached with HCFA for allocating costs in Fiscal Year 1998 should be applicable to Fiscal Year 1999 and future fiscal years with few, if any, adjustments.

DHCPF staff state that the primary problem in completing the Fiscal Year 1997 reconciliation is that the Department has not allocated sufficient staff resources to complete the reconciliation in a more timely manner. Staff state that the reconciliation is now considered a priority and plan to complete and submit it to the federal government during February 1999.

Staff from both the Department and from HCFA indicate that it is imperative for the Department to have an approved cost allocation plan in place, not only because of the need to resolve this lengthy process, but because the Department's operations are becoming increasingly varied as a result of taking on other responsibilities in addition to the Medicaid program. This increases the complexity of the allocation process used for the indirect costs. If an agreed-upon method of allocation is not reached, the possibility of federal deferrals or disallowances could increase. Conversely, the Department could risk underrecovering indirect costs from the federal government.

Recommendation No. 1:

The Department of Health Care Policy and Financing should prioritize the completion of its cost allocation plan and take the necessary steps to obtain approval from the federal Health Care Finance Administration for the plans for Fiscal Years 1995 through 1999.

Department of Health Care Policy and Financing Response:

Agree. The Department will make every effort to complete, negotiate, and obtain federal approval of cost allocation plans for the identified years. We will submit the necessary data to the federal government for Fiscal Year 1997 by March 5, 1999. If approved, this data will be used to settle the cost for Fiscal Years 1995 through 1997. As soon as those years are resolved, the Department will pursue amending the plan for Fiscal Year 1998 and future years to reflect the changes in the Department that occurred in Fiscal Year 1998. We will make every effort to have the amendment approved by the federal government by December 31, 1999. This timeline is dependent on our ability to work with the appropriate federal representatives and to negotiate and obtain approvals. We will work diligently to obtain these approvals.